Issue 3 October 2002

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SMMGP SUBSTANCE MISUSE MANAGEMENT IN GENERAL PRACTICE

A national newsletter on substance misuse management in primary care

The Future of the RCGP Certificate and GP Training

The Royal College of General Practitioners (RCGP) Certificate for GPs with a special clinical interest has entered its second year, funded by the Department of Health and specifically endorsed by David Blunkett, the Home Secretary. The first year was very successful and certificates will be awarded to nearly 400 GPs, mentors and prison doctors on 9th October. Some candidates have had extensions prior to assessment. Wales joined last year and was due to finish the course by the end of September. Next year the Certificate is being opened out to other professional groups, including primary care nurses, pharmacists (for whom accreditation is expected by their college), and general psychiatrists. A significant cadre of GPs with a special clinical interest is now developing. This is starting to be felt at a local level as GPs take a greater clinical and strategic lead in drug dependency treatment. Dr Clare Gerada the Chair of the RCGP Expert Advisory Group and programme director said, "We are seeing a fundamental change in the delivery of drug services, with primary care taking a significant role." The successful format of the previous year will be retained with a few adjustments and the first master classes are due to start in November. All course attendees will automatically receive this newsletter.

When does the new course begin? The new course begins in November with 3 Regional Master Classes (the old Pre-master Class), Training Day 1: Monday 11th November Savoy Place, London; Wednesday 13th November Wills Hall, University of Bristol; Monday 2nd December Hanover Hotel, Warrington. The Training the Mentors day is on Monday 4th November at the RCGP.

How many people are doing the next course? 300 will be doing the course this autumn. 150 GPs are now fully booked with a further 100 still on a waiting list. 50 nurses are fully booked with a further 50 on a waiting list. 50 pharmacists are recruited and hopefully 50 adult psychiatrists will be. The Prison Health Policy Unit is also funding further places for prison doctors and nurses.

Can people still register and will the course be run again? The centrally funded places are full for the practitioner groups but it is possible to purchase places if local funding is available. People's names will still be put on a waiting list in case further central funding is obtained to run the course again next year. However the Department of Health indicated that further funding was extremely unlikely and that local funding would most likely be needed. However, things can change and waiting lists will certainly help argue the case. WATCH THIS SPACE AND APPLY.

When does the Diploma course start and is there a waiting list? The two short-listed bids are now working together on a joint bid. No contract has yet been awarded so the diploma will not be piloted until autumn 2003. People will be able to register their interest at the RCGP.

What about generalists? This is a question that needs asking. One-off money was given 18 months ago for this and it has been spent differently in different areas. This has now come to an end except for London, the Southeast and North Cumbria where programmes are ongoing. There needs to be more sustained and co-ordinated effort to keep generalist training available to GPs who want to treat drug dependency without developing a special clinical interest. These after all represent the vast majority of GPs treating drug dependency. There are good examples from Scotland where the main focus has been on generalist training. The Scottish Shared Care Network has been working with the Scottish Executive and the new Scottish Drugs Training for Alcohol and Drugs (STRADA) to produce a template for generalist training in Scotland. The Scottish Network is awaiting the Executive's response to a joint Network/STRADA proposal on taking generalist training forward.

See views from a certificate participant and mentor on page 4

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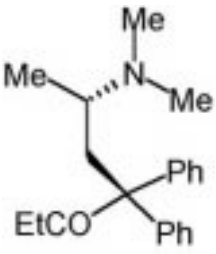
Starting Methadone Safely -

Guidance from the Royal College of General Practitioners (RCGP) Sex, Drugs and HIV Task Group

The Department of Health publication 'Drug Misuse and Dependence: Guidelines in Clinical Management' (1999) provides useful guidance on how to commence someone on a prescription for methadone. The publication has been sent to every doctor in the country.

There is however ample evidence that many doctors have not read this publication. There have been a number of instances over the last couple of years where doctors have started people on methadone in unsafe ways e.g. without checking for evidence of opiate tolerance, starting on doses above 40mg and making no arrangements for daily dispensing or supervised consumption. *Repeated calls to prescribe only in accordance with the UK or local guidelines have not been successful and some problems continue to occur.*



An article in a journal sent out to members of the Medical Defence Union (MDU) advised them when treating patients with drug problems of the need to stick to the Clinical Guidelines. In response the task group decided to develop an information sheet that would be sent to all doctors or made available to doctors during training that set out the minimum requirements to make the initiation of methadone prescribing safer. This initiative is supported by the MDU.

The following text has been approved by the RCGP officers meeting, the RCGP Expert Advisory Group and the RCGP Council. It will then be circulated to every GP. The intention is that each GP will keep it accessible to remind him/her about how to proceed safely when initiating a prescription for methadone. Each GP might wish to add information about their local specialist service (or GP colleague with a special interest) so that this is also available when required.

Starting Methadone Safely

Prescribing methadone mixture is a useful evidence-based approach to supporting people with opiate dependency *but methadone needs to be prescribed safely to avoid the dangers of overdose and diversion.* If you are not familiar with caring for drug users, a decision to start methadone for the first time should be taken with advice from a specialist service or from a GP colleague with a special interest.

- **Always use methadone mixture 1mg/ml** (not tablets or injectables).
- **Before starting methadone mixture for the first time:**
  - Carry out **urine toxicology** to check that there are opiates in the urine (results can take up to a week).
  - **Check for objective signs of opiate dependence** including dilated pupils when the patient is withdrawn.
- ***N.B. Starting methadone is never an emergency.***
  Starting methadone without evidence of opiate dependency can be very dangerous and should never be done.
- **If a substitute prescription of methadone mixture is appropriate:**
  -Start with 20-30mg methadone mixture daily.
  -Be prepared to **see patient** (after 1-2 doses) to **titrate** dose up.
- ***N.B. Deaths have occurred following the commencement of a daily dose of 40mg methadone.***
- **Arrange for the drug user to receive methadone mixture on a daily basis (if possible, supervised for at least the first 12 weeks).**

For more details see Departments of Health publication 'Drug Misuse and Dependence: Guidelines in Clinical Management' (1999) p.45-46.

Binge drinking
risky behaviour?

Binge drinking is an enormous problem that has health and social costs. Heavy episodic drinking is a noticeable feature of people's social lives in the United Kingdom. It is often seen as a subject for amusing anecdotes, a cultural norm or a rite of passage for young people. In 1998 21% of men and 8% of women had drunk 'heavily', having consumed more than eight units and six units respectively, on at least one day in the previous week. Young people are even more inclined to this pattern of behaviour.

Levels - The Government report Sensible Drinking (1995) changed the guidelines for sensible drinking from a weekly to a daily measure of consumption. This reflected concern that: 'weekly consumption can have little relation to single drinking episodes and may indeed mask short term episodes which … often correlate strongly with both medical and social harm'. 'Daily limits' are intended to draw people's attention to **a safe level for moderate regular drinking, and to help people decide how much to 'drink on a single occasion'** and avoid drunkenness.

Binge drinking definitions lack consensus, but include: 'ten or more drinks in one session' (standardised unit of 7.9g of ethanol) or alternatively drinking over half the weekly recommended units for a week in one session i.e. ten units for men and seven units for women based on previous weekly guidance. However, **It is difficult to assess the risks arising from the volume of alcohol consumption alone.** Variables include personality, mood, sex, tolerance to alcohol, and the physical and cultural context. **There is a need to move away from clinical or volume definitions to a clearer 'distinction between responsible and reckless drinking behaviour'. One catchall definition** is 'Drinking sufficient alcohol to reach a state of intoxication in the course of one drinking session.' Risky single occasion drinking (RSOD) describes potentially harmful episodes of heavy social drinking. For a significant proportion of young people binge drinking is not simply a youthful phase but a possible precursor of later, harmful drinking behaviour; 28% of men and 11% of women drink twice the recommended daily benchmarks at least once a week into their mid-forties. The assumption of adult roles generally militates against this continued pattern of drinking but adverse adult life events such as divorce are associated with it.

Effects of binge drinking cause concern - Studies show, that whilst some people can recognise that this type of drinking is harmful to health, only few are motivated to change. Many young people that engage in frequent risky drinking episodes do not acknowledge that their drinking is problematic and often rate themselves as moderate or light drinkers. For them, long-term health risks appear remote, and immediate behavioural consequences avoidable or not significant.

Effect on general mortality - Existing studies show that the relative risk of death from all-cause mortality for middle-aged men who usually binge drink is increased by 3.01. There is an established and clear link between binge drinking and other types of health behaviour. For example, binge drinking was more prevalent among those who smoked regularly (33.4%) and those classified overweight (24%).

Cardiovascular disease - In binge drinking the cardio-protective benefit of regular moderate alcohol drinking do not apply. Mechanisms linking binge drinking to cardiovascular disease have been identified.

Pregnant women are more vulnerable to the adverse effects of binge drinking. *UK guidelines recommend a weekly limit of four units of alcohol for pregnant women, a limit of two units on any one occasion and avoidance of intoxication.* Debate continues on safe limits for pregnant women, but it is clear that intoxication is to be avoided both for its effects on the foetus and as a cause of accidents.

The link between alcohol misuse and mental illness - It is difficult to establish causality in cases of morbidity, but there is a strong association between heavy drinking, depression and suicide. Alcohol had been consumed before 70% of attempted suicides by men and for women before 40%.

Behavioural consequences include - *Accidents:* 25% of all alcohol-related deaths are due to accidents. ***Violence:*** alcohol consumption present in up to 41% of 'contact crime'/assaults. ***Poor social behaviour and drunkenness:*** In 1995, 19,789 people found guilty of drunkenness offences in England & Wales. ***Workplace:*** 8-14 million days lost each year in the UK. ***Unsafe sex:*** possibly leading to unwanted pregnancies or STDs. After drinking alcohol 1 in 7 of 16-24yr olds had unsafe sex (no condom). 1 in 5 had sex they later regretted, 40% agreed that they would be more likely to have casual sex (HEA 1998).

Successful intervention aspects include:

Media campaigns aimed at changing young people's perception of drinking norms for partying.

Peer led discussion about factors that encourage alcohol use and the need for individuals to make their own decisions about health.

Provision of basic facts about alcohol and the risks of intoxication (Foxcroft et al 1997).

Health psychologists argue that motivating people to change their drinking behaviour depends upon beliefs surrounding issues such as: Their vulnerability to harm as a result of their behaviour, the benefits of change, and whether people believe that they can implement strategies for change.

Source and references: Alcohol Concern **Factsheet 20, Binge Drinking** at www.alcoholconcern.org.uk

The RCGP Certificate – changing treatment changing attitudes

View from a Certificate candidate –

Dr Elmer Molave

A year ago I started the RCGP course in drug misuse and refocused my thoughts. I soon realised that every drug misuser had their own tragedy. My drug misusers would tell me how they fell from grace and became entangled in crime and social isolation in a hostile world where treatment was scanty. Their parents would pour out their emotions as they are forced to take drastic actions in order to rescue their children from the cauldron of drug abuse. One parent told me how he locked his daughter in her bedroom so she could not escape to buy heroin.

A referral to the specialist service was the best that I could offer. **When I finished the course, I realised that our specialist service had not embraced the evidence for methadone maintenance treatment.** Patients would undergo a quick Subutex detoxification irrespective of their history, instead of being triaged into the appropriate level of treatment according to the orange Guidelines. Some patients did not even reach this stage, as their motivation would be assessed by how much they could reduce their heroin intake on their own before treatment could be contemplated.

When patients reached the end of their detoxification, the chemical imbalance in their bodies would overcome any motivation they had left. They would use heroin, get discharged and the grim cycle would continue. I have learnt that maintenance treatment could allow patients to progress slowly, whilst the professionals could provide a helping hand in a patient-centred manner.

Nowadays, I find myself battling for changes to our local service with the help of the patients I have maintained on treatment. They would openly admit that they are the lucky ones and are willing to help other patients by campaigning for changes. They were once lost and now their parents have found them. Prior to the course, I would shun drug addicts, but with the confidence I have gained I have become their advocate. The architects of the course with their Orange blueprints have laid strong foundations. The future is bright, the future is orange.

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View from a mentor –

Dr Frances Davies

When asked to repeat the mentoring experience I answered unreservedly yes. Why was this and why did I ever volunteer in the first place? Once as a full time GP on the south coast I was struggling with the management of drug dependant patients against a background of precious little knowledge and open hostility from other local GPs. I now believe wholeheartedly in the legitimacy of the shared care approach. I hoped that as a mentor I would have an opportunity to help spread the word, albeit to a self selected and willing audience. In my work in Oxfordshire I now have a role in development of drug services, and this requires some teaching of GPs, nurses and others. Mentoring would, I thought, give an opportunity to revise and update my knowledge as well as develop some teaching skills, in what I hoped would be a sympathetic arena.

Mentoring has been good for me in all respects, meeting all my expectations and much more. Unexpectedly I have made new friends, re-found old friends and become part of a network of great doctors both locally and nationally. Our RCGP leaders, fellow mentors and all participants that I have met have been enthusiastic, exciting and fun. **What a contrast to the pessimistic and tired attitude of so many GPs!**

But it was not all easy. The first masterclass was a huge ordeal. The reading, in preparation, was impossible as my mind wandered constantly from the topic itself to visions of how the discussion might proceed on "the day". I had to travel a long way to the venue, and concerns about 'lostness' and lateness fought for priority in my overloaded headachy imagination with concerns about knowing nothing and being found out. Actually, it was fine. The participants were great, and had all done homework as asked, leaving me with little to do except keep time. We gelled quickly as a group, and decided that the second masterclass would be closer to home and split into 2 half days. Again, homework was set and done so that those afternoons passed easily and enjoyably, leaving a celebratory feeling of having learnt a lot.

The next big ordeal was the assessments. I already felt that all members of the group had "passed" because by now I knew them well and all had displayed commitment and knowledge tinged with appropriate quizzical scepticism in the masterclasses and during the lunches that had gone with them. However, the challenge of formally assessing colleagues who were by now also friends, without being too teacherly and demanding, or too pally and slack was very difficult, although it did become progressively easier as my confidence grew. I do not know much about "how it was for them" but by consensus I am planning future meetings for the mentor group on a termly basis, using the half-day masterclass format but arranging our own agenda. I think that says it all.

Dr Davies: Chilton Clinic, Warneford Hospital, Headington, Oxford. **FDavies@aol.com**

What's the crack?

The use of crack cocaine started in the UK back in 1983. Freebase cocaine had been used around a decade before that and the use of cocaine as a recreational drug can be traced back to the latter end of the 19th century. Cocaine in its various forms is not a new thing. Yet currently from both media and government we are constantly hearing about crack use reaching 'epidemic proportions'. From my understanding an epidemic is where there is rapid spread, the reality of crack use in this country has been one of steady growth for the past two decades. The image is also different from that which the media wish to portray. Crack is more than twice as expensive as cocaine, it is used by all social classes, covers all age groups from early teens to twilight years and is used by all cultural groups.

So what is the difference between crack and cocaine? Quite simply put, it is similar to the difference between beer and a strong spirit. Cocaine is usually in one of two chemical forms; either an acid state or an alkaloid state. Cocaine hydrochloride is in an acid state and therefore its melting point is too high to lend itself to being smoked, so the preferred easy method of administration is to snort. Crack however is in an alkaloid state which brings the temperature down, allowing it to be smoked. Smoking is the most effective method of introducing cocaine into the body and getting it to the brain so it can have its affect (just think of the priority route for oxygen once it has entered the lungs). Combine this increased effectiveness with ready accessibility, differing social implications plus an incredible high and its not difficult to see the attraction.

This change in drug trend is presenting challenges to all professionals working with dependence as the majority of current knowledge / thinking, practice and policy are based around opiate use. For GPs the implications are no less challenging than for drug workers. Change is needed if we are to provide treatment / services to this group and the basis of this change is knowledge, for if we do not understand, then how can we possibly be expected to offer appropriate treatment?

Fortunately, over the last couple of years, the issue of crack and cocaine dependence has risen on the priority list. This is currently being spearheaded by the newly formed National Treatment Agency who are beginning to develop national strategy, practice and policy. Although it may be twenty years too late it is good to see that we are starting to repair the cracks rather than papering over them.

Aidan Gray, National Co-ordinator of COCA (Conference on Crack and Cocaine) **cokenet@global.co.uk**

Crack guidance

The NTA has put out two practical, informative and user friendly 8 page documents highlighting key issues for service providers and commissioners:

1. **Research into practice: 1a Drug Services' briefing, treating cocaine/crack dependence, The National Treatment Agency, August 2002.** Document highlights a summary of research findings; effectiveness of treatment; engagement and retention; treatment settings; psychological therapies; medicinal therapies; matching clients and therapies; implications for drug services and is well referenced.

2. **Research into practice: 1b Commissioners' briefing, commissioning cocaine/crack services, The National Treatment Agency, August 2002.** Document highlights a summary of research findings; assessing local need; a spectrum of services; engaging and retaining clients; performance indicators; costs and benefits; implications for commissioning and is well referenced.

Both documents are available online at www.nta.nhs.uk

National primary care training on crack

The Conference Organising Committee for the *Management of Drug Users in General Practice* has taken forward a 2002 Conference request for a national crack training event for primary care. This training involves key national partners, pulling together the NTA as part of their national crack programme/strategy, the RCGP Certificate programme, the RCGP Sex, Drugs and HIV Task Group and SMMGP. This partnership will jointly develop guidance for primary care out of the process. The training will take place on Tuesday 14th January at the RCGP and Tuesday 28th January in Manchester (venue to be arranged.) Contact for those interested in training: Monique Tomlinson, e-mail **moniquetomlinson@wdi.co.uk** or phone 0207 928 9152

Paper review

1. A meta-analysis comparing buprenorphine to methadone for treatment of opiate dependence
Barnett P.G., Rodgers J., Bloch D., Addiction 2001; 96: 683-690

This meta-analysis looked at five randomised clinical trials comparing buprenorphine to methadone and found little difference in retention and illicit opiate use. It found substantial variation in outcomes in the different trials that may have been due to differences in dose levels, patient exclusion criteria and provision of psychosocial treatment. It concluded that the differences in the effectiveness of buprenorphine and methadone may be statistically significant, but the differences are small compared to the wide variance in outcomes achieved in different methadone treatment programmes. Further research is needed to determine if buprenorphine treatment is more effective than methadone in particular settings or in particular subgroups of patients.

2. Alcohol consumption and mortality: modelling risks for men and women at different ages
White I. R., Altmann D., Nanchahal K., British Medical Journal, 27th July 2002: 191-194

This paper shows that a direct dose response relation exists between alcohol consumption and risk of death in women aged 16-54 years and in men aged 16-34 years, whereas at older ages the relation is U shaped. The study was undertaken in England and Wales in 1997. It suggests that women should limit their drinking to 1 unit a day up to age 44 years, 2 units a day up to 74 years, and 3 units a day over 75 years. Men should limit their drinking to 1 unit up to the age of 34 years, 2 units up to 44 years, 3 units up to the age of 54 years, and 4 units a day up to age 84 years. They conclude that substantially increased risks of all cause mortality* can occur even in people drinking lower than recommended limits, and especially amongst younger people. (* E.g. Death from cancer of the lip, oral cavity, and colon, essential hypertension, coronary heart disease, stroke, cirrhosis, non-cirrhotic chronic liver disease, injuries and other causes)

3. Methadone maintenance treatment can be provided in a primary care setting without increasing methadone-related mortality: the Sheffield experience, 1997-2000
Keen J., Oliver P., Mathers N., British Journal of General Practice, May 2002: 387-389

Methadone maintenance treatment has been shown in many studies to reduce mortality and morbidity amongst heroin users. This paper shows that as methadone prescribing was increased in Sheffield, by 400 previously untreated opiate dependent patients, over a two-year period (1997 – 2000), there was no increase in methadone-related deaths. It proceeds to question why such a demonstrably effective treatment, which appears to be able to be prescribed and dispensed safely is still so difficult for patients in many areas of the UK to gain access to.

4. Relapse outcomes in a randomised trial of residential and day abuse treatment.
Greenwood G. L. et al Journal of Substance Abuse Treatment 2001; 20: 15-23

This study is one of a few, that randomised alcohol and drug dependent clients to residential rehabilitation or to a similar non-residential programme. It was undertaken in the US in 1990 and both programmes were based on therapeutic community principles. Of the 261 participating and randomised clients, two thirds were abusing crack. Over 90% were re-interviewed after intake. About a third stayed 6 months (completion), slightly more day clients had relapsed in this time but the benefits from residential care had dissipated by one year. 12-18 months after entering treatment about half of both groups had remained abstinent and about a quarter had experienced a relapse. It concludes that for all but the most problematic clients, intensive day programmes can match outcomes from residential rehabilitation at potentially lower cost.

Classics revisited

Motivational interviewing, preparing people for change,

William R. Miller and Stephen Rollnick, 2nd Edition published by Guilford

I find motivational interviewing very useful in day-to-day general practice. Motivational interviewing (MI) is an effective evidence-based approach to overcome the ambivalence that keeps many people from making desired changes in their lives, even after seeking treatment.

On being impressed by Stephen Rollnick presenting at a recent conference, I decided to reread this classic. I was even more delighted when I discovered I could treat myself to a new edition that has just been extensively rewritten and found that it had been expanded, updated and improved. The new edition incorporates emerging knowledge on the process of behaviour change, a growing body of outcome research and discussions of novel applications.

The book explains how to work through ambivalence to facilitate change. It presents detailed guidelines for using the approach, and reflects on the process of learning MI. Specific strategies are outlined for building motivation and strengthening commitment to change, with attention given to: avoiding first-session pitfalls; responding to resistance; enhancing the patient's confidence and recognising readiness to change. Case studies are effectively used to illustrate the technique. This is an excellent 'how-to' book, it is well written and comprehensive and is an essential read for all of us who are trying to help people change their addictive behaviour.

Dr Chris Ford

Dr Fixit

Blood borne viruses screening and vaccination for injecting drug users

'I am a GP and I have just taken an injecting drug user who is new to treatment on to my list. He is very keen to improve his health and reduce his use of injectable street drugs. We discuss blood borne viruses and he is keen to proceed with screening and vaccination. What should I screen for? Should I screen before commencing a vaccination programme? What packages of vaccinations can I give him and what post vaccination checks should I do?'

Injecting drug users are at risk of infection from five blood-borne viruses: Hepatitis A, B, C, D and HIV. I perform the following **tests**:

- **Anti-HBc** for hepatitis B infection. I also ask for **anti-HBs** if there is a history of previous hepatitis B vaccination. Also test for HBsAg (indicator of hepatitis D being present) and if positive then I also request **anti-HDV** for hepatitis D.
- **Anti-HCV** for hepatitis C. If positive, a second confirmatory test is required and can also request a Polymerase Chain Reaction (PCR) test to see if the virus is active (many labs will only do this for specialists after patient referral).
- **Anti-HIV**. I am of the view that this should be performed by most GPs now, providing they are able to answer the patients' initial questions before the test and have considered when and how to give the result.

Testing should be done with the knowledge that the time between exposure and a positive blood test is up to three months for HIV, six months for hepatitis B but up to nine months for hepatitis C. I conduct the following **vaccinations:**

- **Hepatitis B**: I offer hepatitis B vaccination to intravenous drug users at the first visit. The new vaccination schedule is 0, 7 and 21 days and a booster at 12 months (although 90% achieve an adequate antibody level before the 12-month dose). In HIV negative patients, boosters are not needed for at least ten years if anti-HBs antibodies are detected post-vaccination. These can be checked after 6 weeks of completing the course.

  I think that most people are aware of the 0,1,6-month regimen but I have abandoned that in high risk patients, such as drug users, in favour of the ultra-rapid regimen in Patrick Clements Clinic. The Department of Health is recommending the new regimen for use in GUM clinics and I would suggest its use in primary care when working with people who inject drugs.
- **Hepatitis A**: This is indicated in all those who are HBV or HCV carriers or who are at high risk of these conditions or who are living in poor accommodation, hostels or other institutions. The benefit of vaccinating other injecting drug users with hepatitis A vaccine is marginal. However, as a high proportion of injecting drug users is eligible for hepatitis A vaccination, there is an argument for giving the combined hepatitis A and B vaccine routinely.

Dr Gary Brook, Consultant GUM, Patrick Clements Clinic, Central Middlesex Hospital Gary.Brook@nwlh.nhs.uk

Dr Fixit on methadone and driving

'A regular patient of mine is on 80mls of oral methadone prescribed by me. His urine screens show only methadone. He has not injected for many years. He is very stable, living at home with his wife and two children. He enjoys driving and wants to get a job as a minicab driver. How would you advise him regarding driving on his current dose of methadone?'

Advising a patient on driving fitness where there is dependency is not straightforward even with methadone maintenance in place. The DVLA considers multiple substance misuse including alcohol, (not an uncommon dependency scenario) incompatible with licensing fitness. Regarding this patient, I would check that he had notified DVLA concerning his methadone prescription. In principle he *can* drive on methadone maintenance, or indeed on a buprenorphine programme, under DVLA regulations:

'Applicants or drivers complying fully with a Consultant supervised oral Methadone maintenance programme may be licensed, subject to favourable assessment and, normally, annual medical review. Applicants or drivers on an oral buprenorphine programme may be considered applying the same criteria.'

However, this is normally after an initial 1 or 3-year licence refusal/revocation relating to dependency, and also subject to an assessment and a review. Minicab drivers operate on a regular licence like other car drivers, but more stringent conditions apply (E.g. a 3-year revocation and an expert panel review). The definition of a 'Consultant supervised oral methadone maintenance programme' may be unclear in today's varied service provision. An independent medical assessment may to be the order of the day.

Responsibility to notify the DVLA? Patients who are misusing drugs should notify DVLA themselves. The doctor's responsibility is to ensure that they are told to do this. If the patient does not notify DVLA then the doctor should endeavour to persuade the patient to do so. If the patient represents a serious risk (e.g. chaotic polydrug user), then the doctor may notify DVLA – it is good practice to let the patient know you are doing this beforehand. **More comprehensive guidance can be sought from the DVLA Medical Branch** or on www.dvla.gov.uk under the Medical Rules in the Drivers Homepage section, Driving Regulations at a Glance.

Bulletin Board

Update for primary care. The RCGP Sex, Drugs and HIV Task Group has recently expanded its newsletter 'Update'. The new newsletter remit includes HIV, sexual health, drugs and hepatitis. Current articles include *The changing evidence around oral sex and the transmission of HIV*, and *a response to the DH document The National Strategy for sexual health and HIV*'. To be on the mailing list, please contact Kathleen Dyer, The Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU, e-mail kdyer@rcgp.org.uk

Review of the literature on effective treatments for opiate dependence. The Effective Interventions Unit (a Scottish organisation) has just published an extremely thorough and strong review on effective treatments. Essential reading for all:
http://www.drugmisuse.isdscotland.org/eiu/pubs/eiu_opi.htm

The 1st National Drug Treatment Conference. Treatment Choices: what works, what's new and what's on offer? Thursday 6 and Friday 7 March 2003 in London. A major international 2-day conference bringing together researchers, clinicians and drug users from Australia, America, Europe and the UK. The conference is PGEA approved and accredited for the RCGP Certificate in the Management of Drug Misuse. Contact Monique Tomlinson on 020 7928 9152, e-mail monique@exchangeconferences.org, or www.exchangeconferences.org.

Brown and White conference 25th Nov 2002. A national one day conference organised by COCA (Conference on crack and cocaine) and Release looking at the combined use of Crack and heroin. Details from Ruth Reid at COCA, tel. 020 7729 5513, e-mail cokenet@global.co.uk

Conference - The Royal College of Psychiatrists and the Society for the Study of Addictions. GPs welcome to a joint College/Society residential conference in Leeds, 28 - 29th November. Wide variety of topics - tobacco and mental health, drug-related deaths etc. Should be an exciting multi-disciplinary meeting but also good social event. Contact Gill Gibbins at grgibbins@rcpsych.ac.uk

Safer Heroin booklet - written and published by The Release Heroin Helpline. It aims to look at heroin use from a harm reduction perspective, starting with the notion that abstinence based information has little or no practical relevance to most heroin users. Sections include 'You and the law', 'Blood borne viruses and other infections',' Overdose', 'A transition to injecting?' and 'Managing your dose'. It is 20 pages of text at £2 per copy or free to individual service users. Check it out. Gary Sutton on 020 7749 4053 gary@release.org.uk

How do General Practitioners feel about being involved in managing substance misuse problems? This report from Substance Misuse.Net on Swansea GP's attitudes may be of interest to members. Alan Joyce.
http://www.substancemisuse.net/practitioners/pfeatures/003/page02.htm

'Models of Care' workshops - The National Treatment Agency for Substance Misuse (NTA) is holding a series of one-day workshops around the country on the implementation of Models of Care, the new service framework for drug treatment. These are from late October through November and are free. Contact Marie Therese Keegan, Tel. 020 7972 2376 Fax 020 7972 2248 Email *tempnta3@nta.gsi.gov.uk*. Further details and online booking on www.nta.nhs.uk, where *the updated edition of Models of Care is available on-line.*

Home Office Drug Strategy Directorate (DSD) publications have recently reviewed their distribution and publication. To receive regular updates on publications you can register on line at: www.drugs.gov.uk/register or obtain documents from the resources room. For example new reports on drug treatment for women and Black and ethnic-minority communities
:www.drugs.gov.uk/ReportsandPublications

Hot Topic - Hepatitis C Strategy for England

In August 2002 the Government published this strategy for consultation. It aims to raise professional and public awareness of hepatitis C and sets out proposals to improve the effectiveness of prevention, diagnosis and treatment services. Injecting drug users are a key target group. The main proposals in the strategy include: **measures for raised public and professional awareness of hepatitis C; intensified efforts to prevent new cases of hepatitis C infection with the enhancement of harm reduction services, including needle exchange; increased diagnosis of people at current or past risk of infection; development of managed clinical networks to provide accessible specialist assessment and treatment; improved evidence base for treatment and prevention through epidemiological surveillance and research.**

Treatment for Hepatitis C - Dr Graham Foster recently spoke at our RCGP Managing Drug Users in General Practice Conference outlining the great leaps forward in treatment for hepatitis C. Genotype 2 and 3 are obtaining 70 - 80% cure using *pegylated* interferon and ribavirin. The situation with genotype 1, sometimes called 'the rottweiller', although less impressive is nevertheless at 40 - 50% cure. Unfortunately, access to that treatment is not always straight forward and resulted in the following conference consensus statement:

- **In view of recent improvements in the management of hepatitis C, we suggest that the government urgently review treatment guidance to PCTs and other commissioners to facilitate expansion of current treatment capacity.**
- **There is evidence that discrimination may prevent some IV drug users from effective treatment and we deplore this.**

Hopefully the new strategy will address the first point and *we* need to ensure that discrimination in access to treatment is prevented. **The full strategy is available at** www.doh.gov.uk/cmo/hcvstrategy

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NETWORK NEWSLETTER IS SPONSORED BY SCHERING-PLOUGH LTD

Network ISSN 1476-6302

SMMGP works in partnership with

1952-2002

Trafford Substance Misuse Services

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National Treatment Agency for Substance Misuse

SMMGP is funded by the Treasury, Invest to Save Budget

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